WORKERS' COMPENSATION TELEPHONE REPORTING WORKSHEET

THINGS TO REMEMBER WHEN COMPLETING THE INFORMATION BELOW:
Call the Telephone Reporting Center to quickly and easily report all Workers' Compensation injuries. We will be asking you the following questions, so please have the information handy. We will produce and submit the necessary state forms.

DO NOT DELAY IN CALLING IF YOU DO NOT HAVE ANSWERS TO ALL THE QUESTIONS.

ACCOUNT / ACCIDENT INFORMATION

CALLER'S PHONE NUMBER / EXTENSION	CALLER'S TITLE	CALLER'S NAME	REPORTING STATE
( )			

SUBSIDIARY NAME	SUBSIDIARY'S ADDRESS (STREET, CITY, STATE & ZIP)	SUBSIDIARY'S MAILING ADDRESS (STREET, CITY, STATE & ZIP)
		☐ SAME

DID THE ACCIDENT OCCUR AT THE LOCATION ADDRESS?
☐ YES ☐ NO IF NO, ADDRESS WHERE ACCIDENT OCCURRED

PARENT COMPANY / INSURED'S NAME

LOCATION CODE	POLICY SYMBOL AND NUMBER	NATURE OF BUSINESS

DATE OF INJURY	TIME OF INJURY

ACCIDENT DESCRIPTION

EMPLOYEE INFORMATION

INJURED EMPLOYEE'S SOCIAL SECURITY NUMBER:	EMPLOYEE'S NAME (FIRST, MI, LAST)	GENDER
		☐ MALE ☐ FEMALE

DATE OF BIRTH	EMPLOYEE'S MAILING ADDRESS

EMPLOYEE'S HOME PHONE NUMBER	EMPLOYEE'S HOME ADDRESS (IF DIFFERENT FROM MAILING)
( )	

EMPLOYEE JOB INFORMATION

EMPLOYMENT STATUS CODE	INJURED WORKER TYPE	REGULAR OCCUPATION
☐ FULL-TIME ☐ PART-TIME ☐ OTHER_____		

OCCUPATION WHEN INJURED

EMPLOYEE'S WORK SCHEDULE
REGULAR WORK HOURS HOURS/DAY DAYS/WEEK

EMPLOYEE'S WAGE INFORMATION:
$ _____ / HOUR OR $ _____ / ANNUAL OR $ _____ / WEEKLY OVERTIME: $ _____ ADDITIONAL BENEFITS: $ _____.

DATE OF HIRE OR LENGTH OF EMPLOYMENT

SUPERVISOR'S NAME:	SUPERVISOR'S PHONE NUMBER:	BEST HOURS TO CONTACT
	( )	

ACCIDENT INFORMATION

DATE CLAIM REPORTED TO EMPLOYER?	DID EMPLOYEE LOSE ANY TIME FROM WORK?	IS THE EMPLOYEE BACK AT WORK?
	☐ YES ☐ NO	☐ YES ☐ NO IF YES, DATE RETURNED TO WORK?

RETURN TO WORK STATUS	DATE EMPLOYEE LAST WORKED	WAS INJURY FATAL? IF YES, DATE OF DEATH
☐ LIGHT ☐ MODIFIED ☐ REGULAR		☐ YES ☐ NO

CAUSE OF ACCIDENT (E.G., SLIP/FALL, LIFTING, CHEMICAL)

EQUIPMENT, MATERIAL OR SUBSTANCE INVOLVED

DO YOU QUESTION THE VALIDITY OF THE CLAIM?
☐ YES ☐ NO

WITNESS INFORMATION/OTHERS INVOLVED
NAME (FIRST, MI, LAST) ADDRESS PHONE NUMBER

CONTINUED ON REVERSE SIDE

INJURY INFORMATION

PART OF BODY INJURED (E.G., HEAD, NECK, ARM, LEG)

NATURE OF INJURY (E.G., FRACTURE, SPRAIN, LACERATION

PRIOR INJURY OR PRE-EXISTING CONDITION(S) (IF YES, DESCRIBE)

☐ YES ☐ NO

TREATMENT ("X" ALL THAT APPLY

☐ FIRST AID —	TREATMENT AND DATE OF 1ST TREATMENT
☐ HOSPITAL/ CLINIC —	NAME, ADDRESS, PHONE NUMBER, PHYSICIAN NAME, TREATMENT, DATE OF 1ST TREATMENT, LENGTH OF STAY, AMBULANCE USED? WAS EMPLOYEE TREATED IN AN EMERGENCY ROOM? ☐ YES ☐ NO WAS EMPLOYEE HOSPITALIZED OVERNIGHT AS AN IN-PATIENT`? ☐ YES ☐ NO
☐ PHYSICIAN —	

SEE WORKERS' COMPENSATION - FIRST REPORT OF INJURY - STATE SPECIFIC QUESTIONS FOR YOUR INDIVIDUAL STATE.

CUSTOMER SPECIFIC INFORMATION

ADDITIONAL COMMENTS & INFORMATION